



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Office of Audit Services  
1100 Commerce, Room 632  
Dallas, Texas 75242

July 13, 2007

Report Number: A-06-03-00078

Barry Goldstein  
Administrator  
Gulf Health Care Center  
1720 North Logan Street  
Texas City, Texas 77590

Dear Mr. Goldstein:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) final report entitled "Review of Rehabilitation Services at Gulf Health Care, Texas City, TX." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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If you have any questions or comments about this report, please do not hesitate to call me or Cheryl Blackmon, Audit Manager at (214) 767-9205 or through e-mail at [cheryl.blackmon@oig.hhs.gov](mailto:cheryl.blackmon@oig.hhs.gov). To facilitate identification, please refer to report number A-06-03-00078 in all correspondence.

Sincerely,

A handwritten signature in black ink, reading "Gordon L. Sato", is written over a horizontal line.

Gordon L. Sato  
Regional Inspector General  
For Audit Services

Enclosures – as stated

Page 2 – Mr. Goldstein

**Direct Reply to HHS Action Official:**

James R. Farris, M.D.  
Regional Administrator, Region VI  
Centers for Medicare & Medicaid Services  
1301 Young Street, Suite 714  
Dallas, Texas 75202

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF REHABILITATION  
SERVICES AT GULF HEALTH  
CARE, TEXAS CITY, TEXAS**



Daniel R. Levinson  
Inspector General

July 2007  
A-06-03-00078

# ***Office of Inspector General***

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### **OAS FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Medicare pays skilled nursing facilities (SNF) a daily rate to cover skilled services (e.g., rehabilitation therapy, infusion therapy, nursing, etc.) provided to Medicare patients during each day of a covered SNF stay. SNFs use a uniform clinical assessment form called a Minimum Data Set (MDS) to classify patients into specific payment groups known as Resource Utilization Groups (RUG) based on the patient's care and resource needs. Each RUG corresponds to a combination or bundle of services (e.g., skilled nursing services, daily physical therapy, and ancillary services). SNFs periodically assess patients' clinical progress and may adjust the MDSs. Substantial changes may result in either higher or lower RUGs and thus higher or lower payments.

A single SNF claim may have multiple RUGs, with each RUG covering a different period and corresponding to a different payment rate. When claims have multiple RUGs, medical reviewers must evaluate each RUG independently. As a result, medical reviewers may make multiple determinations on a single claim.

### **OBJECTIVE**

Our objective was to determine whether the services on rehabilitation claims paid to Gulf Health Care Center (Gulf) of Texas City, Texas, were medically necessary and adequately supported by medical documentation.

### **SUMMARY OF FINDINGS**

Of the 100 rehabilitation claims sampled, medical reviewers determined that 69 included medically unnecessary documented services and recommended that 30 claims be allowed. One claim was not counted as an error because the claim was erroneously billed by Gulf and, subsequently, was not paid by the intermediary. All 100 claims were adequately supported by medical documentation.

For the 69 claims (containing 108 RUGs) that included medically unnecessary services, the medical reviewers recommended that 13 RUGs be denied because all of the services were not medically necessary at the intense level provided at an SNF and that 95 RUGs be coded at a lower level (downcoded) because some of the services within each RUG were not medically necessary at the level indicated on the claim.

These errors occurred because Gulf misapplied Medicare medical necessity requirements. As a result, we estimate Medicare overpaid Gulf at least \$671,456 for services that did not meet Medicare requirements.

## **RECOMMENDATIONS**

We recommend that Gulf:

- refund to the Medicare program \$671,456 in overpayments for improperly paid rehabilitation claims,
- ensure that future rehabilitation claims comply with Medicare requirements on medical necessity,
- strengthen its procedures to ensure that all Medicare claims are supported by adequate medical documentation, and
- work with the fiscal intermediary to determine the amount of overpayments made subsequent to our audit period.

## **GULF'S COMMENTS**

In its October 28, 2005, written comments on our draft report, Gulf strongly disagreed with our findings and took issue with many aspects of the review, which include issues involving medical necessity determinations and medical documentation. Specifically, according to Gulf's comments, the review:

- mentioned dementia, Alzheimer's disease, or other cognitive impairments as the basis of denying therapy to patients;
- failed to consider the patient's home environment in instances where therapy was denied and home health care was considered appropriate;
- overlooked physician orders for therapy care;
- failed to consider RUG downgrades for claims recommended for a denial;
- failed to apply Medicare Program Integrity guidelines; and
- recommended claims for denial based on missing or inadequate documentation that was easily found in patients' files.

The full text of Gulf's comments (excluding privacy information) is included as Appendix C.

## **OFFICE OF INSPECTOR GENERAL'S RESPONSE**

Upon our initial visit to Gulf to collect medical documentation, we noted Gulf's weak internal controls related to how the facility maintains and stores documentation. In many instances, documents in patient files could not be found and many documents were provided to us in piecemeal.

After the receipt of our draft report, Gulf sent us additional documentation to support its position. Based on the documentation, we decided to request a second review of claims that originally included RUGs recommended for a denial or downcode. However, during the second review,

medical reviewers noted numerous instances where documentation was still missing. Gulf later provided us with these records.

After we obtained additional information from Gulf's medical records, the medical reviewers were satisfied with all documentation received and made medical review determinations on all claims reviewed.

As a result of the second review, medical reviewers revised 78 of their original determinations involving issues on medical necessity or documentation. In total, 69 of the 100 claims selected for review included medically unnecessary services. As a result, we estimate Medicare overpaid Gulf at least \$671,456 for services that did not meet Medicare requirements. We have adjusted this report to reflect the revised estimated overpayments.



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## **INTRODUCTION**

### **BACKGROUND**

#### **Medicare Prospective Payment System for Skilled Nursing Facilities**

The Balanced Budget Act of 1997 mandated the implementation of a prospective payment system for skilled nursing facility (SNF) services furnished to beneficiaries under Part A of the Medicare program. SNFs provide daily services that include speech, occupational, and physical therapies, intravenous feedings or medications, and transfusions. Services must be provided by, or under the direct supervision of, skilled nursing or rehabilitation professionals for a condition previously treated at a hospital.

Under the prospective payment system, Medicare pays SNFs a daily rate to cover skilled services (e.g., rehabilitation therapy, infusion therapy, nursing, etc.) provided to a patient during each day of a covered SNF stay. SNFs use a uniform clinical assessment form called a Minimum Data Set (MDS) to classify the patient into an appropriate payment group, known as a Resource Utilization Group (RUG), based on the patient's care and resource needs. Each RUG corresponds to a combination or bundle of services (e.g., skilled nursing services, daily physical therapy, and ancillary services).

Federal regulations require SNFs to complete periodic MDSs, beginning with the 5<sup>th</sup> day of the patient's stay, again on the 14<sup>th</sup>, 30<sup>th</sup>, 60<sup>th</sup>, and 90<sup>th</sup> days, and whenever the patient's medical condition changes. The 5-day MDS includes the patient's initial recommended treatment and the corresponding RUG. Based on the patient's progress, SNFs may adjust subsequent MDSs. If substantial, these adjustments may result in either a higher or lower RUG and thus a higher or lower payment.

A single SNF claim may have multiple RUGs, with each RUG covering a different period and corresponding to a different payment rate. When claims have multiple RUGs, medical reviewers must evaluate each RUG independently. As a result, medical reviewers may make multiple determinations on a single claim.

#### **Resource Utilization Groups**

During the scope of our review, Medicare grouped RUGs into seven major service categories: rehabilitation, extensive services, special care, clinically complex, impaired cognition, behavior problems, and reduced physical functions. Rehabilitation services were further divided into five levels that comprised of 14 RUGs: ultrahigh (3 RUGs), very high (3 RUGs), high (3 RUGs), medium (3 RUGs), and low (2 RUGs). Each RUG was associated with a per diem payment rate.

The Centers for Medicare & Medicaid Services (CMS) has expressed concern about the health risks of unnecessary rehabilitation therapy. In response to public comment, CMS stated:

“We expect facilities will not compromise any beneficiary’s health by beginning rehabilitation therapy prematurely or at a level that is too rigorous for the individual’s status.”<sup>1</sup>

## **Medicare Program Safeguard Contractors**

The Health Insurance Portability and Accountability Act of 1996 established the Medicare Integrity Program, in part, to strengthen CMS’s ability to deter fraud and abuse in the Medicare program. In accordance with this legislation, CMS created program safeguard contractors to perform functions such as medical review, cost report audits, data analysis, provider education, and fraud detection and prevention. Under a contract with CMS, TriCenturion performs fraud and abuse safeguard functions for the Medicare Part A workload in Texas. TriCenturion performed the original medical review and medical rereview for this audit.

## **Gulf Health Care Center**

Located in Texas City, Texas, Gulf Health Care Center (Gulf) is a nursing home with a Medicare-certified skilled nursing unit.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether the services on rehabilitation claims paid to Gulf were medically necessary and adequately supported by medical documentation.

### **Scope**

We selected Gulf for our review because the nursing home had the highest percentage of its rehabilitation services in the costliest rehabilitation RUG - more than any other Texas nursing home submitting claims to Mutual of Omaha<sup>2</sup> during calendar year 2002.

From July 2, 2002, through May 31, 2003,<sup>3</sup> Gulf submitted 401 Medicare claims totaling \$2,089,053. For our audit, we selected 387 paid claims with payments totaling \$2,071,612. Each claim included at least one rehabilitation service period. From the 387 rehabilitation claims, we selected an unrestricted random sample of 100 claims (containing 163 RUGs) totaling \$523,370. All 163 RUGs were rehabilitation RUGs.

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<sup>1</sup>Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities, 64 Federal Register 41657 (1999).

<sup>2</sup>Mutual of Omaha is a Medicare fiscal intermediary that processes Medicare claims for Gulf.

<sup>3</sup>According to Medicare regulations, nursing homes are required to keep payment-setting documentation in the current medical record for only 15 months. Therefore, we selected our data from the most recent data available for the 15-month period before October 2003, which is when we selected the data.

We limited our review of internal controls to gaining an understanding of Gulf's procedures for completing the SNF patients' MDSs and its policies and procedures for maintaining medical records.

We performed our fieldwork at Gulf in Texas City, Texas.

## **Methodology**

To accomplish our objective, we:

- reviewed the applicable laws, regulations, and guidance concerning the Medicare payment process for SNFs;
- interviewed Gulf officials and reviewed Gulf's policies and procedures for (1) assessing patients' care needs and completing the MDSs and (2) ensuring completeness of the nursing home's medical records;
- obtained Gulf's medical records for the 100 sample claims;
- forwarded the medical records for the sample claims to TriCenturion's medical reviewers to determine whether the claimed services were medically necessary and supported by adequate documentation;
- obtained the medical review results on the sample claims and calculated the overpayment amounts; and
- estimated total Medicare overpayments based on our sample results.

Appendix A includes our sampling methodology and the resulting projection of overpayments.

We conducted our audit in accordance with generally accepted government auditing standards.

## **FINDINGS AND RECOMMENDATIONS**

Of the 100 rehabilitation claims sampled, medical reviewers determined that 69 included medically unnecessary documented services and recommended that 30 claims be allowed. One claim was not counted as an error because the claim was erroneously billed by Gulf and, subsequently, was not paid by the intermediary. All 100 claims were adequately supported by medical documentation.

For the 69 claims (containing 108 RUGs) that included medically unnecessary services, the medical reviewers recommended that 13 RUGs be denied because all of the services were not medically necessary at the intense level provided at an SNF and that 95 RUGs be coded at a lower level (downcoded) because some of the services within each RUG were not medically necessary at the level indicated on the claim.

These errors occurred because Gulf misapplied Medicare medical necessity requirements. As a result, we estimate Medicare overpaid Gulf at least \$671,456 for services that did not meet Medicare requirements.

Appendix B contains a more detailed breakdown of the medical reviewers' findings on the 100 sample claims.

## **SERVICES WERE NOT MEDICALLY NECESSARY**

### **Medicare Requirements Govern Medical Necessity**

Pursuant to 42 CFR § 409.31(b), Medicare generally covers skilled care if (1) the beneficiary requires skilled nursing or rehabilitation, or both, daily; (2) the beneficiary needs care for a condition previously treated in a hospital or critical access hospital; and (3) the skilled services, as a practical matter, can be provided only in an SNF on an inpatient basis.

Regulations (42 CFR § 409.44(c)(2)) state that physical and occupational therapy and speech-language pathology services must be reasonable and necessary. To be considered reasonable and necessary, the following conditions must be met: (i) the services must be considered under accepted standards of medical practice to be a specific, safe, and effective treatment for the beneficiary's condition; (ii) the services must be of such a level of complexity and sophistication or the condition of the beneficiary must be such that the services required can safely and effectively be performed only by a qualified physical therapist or by a qualified physical therapy assistant under the supervision of a qualified physical therapist, by a qualified speech-language pathologist, or by a qualified occupational therapist or a qualified occupational therapy assistant under the supervision of a qualified occupational therapist; (iii) there must be an expectation that the beneficiary's condition will improve materially in a reasonable (and generally predictable) period of time based on the physician's assessment of the beneficiary's restoration potential and unique medical condition, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific disease, or the skills of a therapist must be necessary to perform a safe and effective maintenance program; and (iv) the amount, frequency, and duration of the services must be reasonable.

Pursuant to 42 CFR § 424.20(a)(1), an SNF patient must be correctly assigned to one of the RUGs designated as representing the required level of care. Moreover, 42 CFR § 483.20(i)(2) states that the MDS assessment must be accurate and that each person who completes a portion of the MDS must certify its accuracy.

### **Gulf Provided Services That Were Not Medically Necessary**

The medical reviewers determined that 69 claims included rehabilitation therapy that did not fully meet Medicare requirements for medical necessity. For most of the 69 claims, the reviewers cited multiple reasons that led to their recommendations to either deny or downcode the claims. Two examples illustrate these multiple reasons.

- A 69-year-old patient with a history of hypertension, chronic obstructive pulmonary disease, and gout was hospitalized due to weakness, altered mental status, and alcohol intoxication. The patient's gait had deteriorated prior to being hospitalized and the patient had started using a walker and a wheelchair. A CT of the head led to a diagnosis of brain disease and generalized debilitation. While hospitalized, records stated that the patient's short-term memory was profoundly impaired, which limited his rehabilitation potential. On the date the patient transferred from the hospital to Gulf, the patient's physician noted that the patient seemed unable to understand that he should call for help when getting out of bed. Approximately one week later, the physician stated that the patient was not manageable in a nursing home setting and was unable to participate in rehabilitation. According to the medical reviewers, the skills of a licensed therapist were not reasonable or necessary. They recommended that the RUG on the claim be downcoded from a rehabilitation ultra-high level to a clinically complex level based on the frequency of physician visits and orders.
- A 72-year-old patient was hospitalized due to nonsustained ventricular tachycardia on pacemaker monitoring and pacemaker follow-up. After transferring to Gulf, the patient underwent an assessment, which indicated that the patient was able to perform most daily living activities independently. Thus, medical reviewers stated that there was no need for skilled rehabilitation. Moreover, the medical documentation did not indicate a need for any skilled services. Therefore, the medical reviewers recommended that all RUGs on the claim be denied.

### **Gulf Misapplied Medicare Requirements on Medical Necessity**

During an exit conference to discuss the results of our initial review, Gulf's corporate officials asserted that the Medicare requirements authorize the rehabilitation services provided at Gulf. Gulf later provided us with additional documentation to support its opinion after we issued our draft report to the facility. Based on the documentation provided by Gulf, medical reviewers conducted a second review and revised 78 of their original determinations.<sup>4</sup>

As a result of the second review, medical reviewers determined that Gulf provided services that did not meet Medicare requirements for medical necessity. Based on the demonstrated medical expertise of the medical reviewers, we concluded that Gulf misapplied Medicare medical necessity requirements.

### **CONCLUSION**

For the period July 2, 2002, through May 31, 2003, we estimate Medicare overpaid Gulf at least \$671,456 for services that were medically unnecessary.

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<sup>4</sup>We have adjusted this report to reflect the revised estimated value of overpayments.

## **RECOMMENDATIONS**

We recommend that Gulf:

- refund to the Medicare program \$671,456 in overpayments for improperly paid rehabilitation claims,
- ensure that future rehabilitation claims comply with Medicare requirements on medical necessity,
- strengthen its procedures to ensure that all Medicare claims are supported by adequate medical documentation, and
- work with the fiscal intermediary to determine the amount of overpayments made subsequent to our audit period.

## **GULF'S COMMENTS**

In its October 28, 2005, written comments on our draft report, Gulf strongly disagreed with our findings and took issue with many aspects of the review, which include issues involving medical necessity determinations and medical documentation. Specifically, according to Gulf's comments, the review:

- mentioned dementia, Alzheimer's disease, or other cognitive impairments as the basis of denying therapy to patients;
- failed to consider the patient's home environment in instances where therapy was denied and home health care was considered appropriate;
- overlooked physician orders for therapy care;
- failed to consider RUG downgrades for claims recommended for a denial;
- failed to apply Medicare Program Integrity guidelines; and
- recommended claims for denial based on missing or inadequate documentation that was easily found in patients' files.

The full text of Gulf's comments (excluding privacy information) is included as Appendix C.

## **OFFICE OF INSPECTOR GENERAL'S RESPONSE**

Upon our initial visit to Gulf to collect medical documentation, we noted Gulf's weak internal controls related to how the facility maintains and stores documentation. In many instances, documents in patient files could not be found and many documents were provided to us in piecemeal.

After the receipt of our draft report, Gulf sent us additional documentation to support its position. Based on the documentation, we decided to request a second review of claims that originally included RUGs recommended for a denial or downcode. However, during the second review,

medical reviewers noted numerous instances where documentation was still missing. Gulf later provided us with these records.

After we obtained additional information from Gulf's medical records, the medical reviewers were satisfied with all documentation received and made medical review determinations on all claims reviewed.

As a result of the second review, medical reviewers revised 78 of their original determinations involving issues on medical necessity or documentation. In total, 69 of the 100 claims selected for review included medically unnecessary services. As a result, we estimate Medicare overpaid Gulf at least \$671,456 for services that did not meet Medicare requirements. We have adjusted this report to reflect the revised estimated overpayments.



# **APPENDIXES**

## SAMPLING METHODOLOGY

**Population:** The population consisted of all paid Medicare claims having at least one rehabilitation service for Gulf Health Care Center (Gulf) of Texas City, Texas, for the period July 2, 2002, through May 31, 2003. During this period, Gulf submitted 387 claims that included at least 1 rehabilitation service period, for a total of \$2,071,612.

**Sample Unit:** The sample unit consisted of a paid claim that included at least one rehabilitation service.

**Sample Design:** We used an unrestricted random sample, selecting 100 sample units for this review.

**Value of an Error:** If the medical review determined that the services recorded on the claim were not medically necessary or adequately documented, those services were disallowed, and that portion paid on the claim was considered an overpayment.

**Estimation Methodology:** We used the Office of Audit Services's statistical sampling software (RAT-STATS) to project the overpayment amount. We reported the estimate of unallowable claims at the lower limit of the 90-percent two-sided confidence interval.

### Sample Results:

Population	Sample Size	Value of Sample	Number of Errors	Value of Errors
387	100	\$523,370.38	69 <sup>5</sup>	\$207,375.49

### Projection:

Point Estimate	90% Confidence Interval	
	Lower Limit	Precision Amount
\$802,543	\$671,456	\$131,087

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<sup>5</sup>Although the medical reviewers found errors on 70 claims, only 69 claims resulted in an overpayment. The remaining claim had no effect on the sample's overall overpayment projection because it showed a payment amount of \$0.

### MEDICAL REVIEW DETERMINATIONS FOR THE 100 SAMPLE CLAIMS

A single claim may have multiple Resource Utilization Groups (RUG), and each RUG may cover a different period and correspond to a different payment rate. When claims have multiple RUGs, medical reviewers must evaluate each RUG independently and make individual decisions on each one. The table below summarizes the medical review determinations for the 100 sample claims, including the total number of RUGs for each determination category and a breakdown of the number of RUGs that the reviewers recommended be denied, paid at a lower RUG level (downcoded), and allowed.

#### Summary of RUGs for the 100 Sample Claims

Medical Determination	No. of Claims	Total No. of RUGs	Recommendations		
			No. of RUGs Denied	No. of RUGs Downcoded	No. of RUGs Allowed
Allowed	30	53	--	--	53
Medically Unnecessary	69	108	13	95	--
Zero Paid Claim not Counted in Sample	1	2	--	--	--
<b>Total</b>	<b>100</b>	<b>163</b>	<b>13</b>	<b>95</b>	<b>53</b>

#### Detail of RUGs for the 100 Sample Claims

The table below lists detailed information for the 100 sample claims reviewed and the medical reviewers' recommendation for each claim.

Sample No.	Error Category <sup>7</sup>	Total No. of RUGs	Recommendations		
			No. of RUGs Denied	No. of RUGs Downcoded	No. of RUGs Allowed
1	M	1		1	
2	M	1		1	
3	M	1		1	
4	A	3			3
5	M	2	2		
6	M	1		1	
7	M	2		2	
8	M	1		1	
9	A	2			2
10	M	2		2	
11	M	1		1	
12	M	2		2	
13	M	2		2	
14	M	1		1	
15	M	3		3	
16	M	3	3		

**APPENDIX B**

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<b>Sample No.</b>	<b>Error Category<sup>7</sup></b>	<b>Total No. of RUGs</b>	<b>No. of RUGs Denied</b>	<b>No. of RUGs Downcoded</b>	<b>No. of RUGs Allowed</b>
17	M	2		2	
18	A	1			1
19	M	2		2	
20	A	2			2
21	A	2			2
22	A	2			2
23	M	1		1	
24	A	1			1
25	A	2			2
26	M	1	1		
27	A	1			1
28	M	3	3		
29	M	1		1	
30	A	3			3
31	A	3			3
32	M	1		1	
33	M	2		2	
34	A	1			1
35	M	2		2	
36	M	2		2	
37	M	2		2	
38	M	1		1	
39	A	1			1
40	A	2			2
41	A	1			1
42	M	3		3	
43	A	2			2
44	M	2		2	
45	M	2		2	
46	M	2		2	
47	M	2		2	
48	M	2		2	
49	M	1	1		
50	A	1			1
51	M	2		2	
52	A	2			2
53	M	1		1	
54	M	1		1	
55	M	1		1	
56	M	1		1	
57	M	1		1	
58	A	1			1
59	M	1		1	
60	A	2			2
61	M	2		2	
62	M	1		1	
63	M	2		2	
64	M	2		2	
65	A	2			2

**APPENDIX B**

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Sample No.	Error Category <sup>7</sup>	Total No. of RUGs	No. of RUGs Denied	No. of RUGs Downcoded	No. of RUGs Allowed
66	M	1		1	
67	M	2		2	
68	M	1		1	
69	M	3		3	
70	A	1			1
71	A	3			3
72	M	2		2	
73	A	3			3
74	M	2		2	
75	M	1		1	
76	A	1			1
77	M	1		1	
78	M	1		1	
79	M	1		1	
80	M	1	1		
81	M	3		3	
82	M	1	1		
83	A	1			1
84	M	2		2	
85	M	1		1	
86	A	1			1
87	A	1			1
88	M	1		1	
89	M	1		1	
90	M	1		1	
91	M	3		3	
92	M	1		1	
93	M	1		1	
94	M	1		1	
95	C	2			
96	M	2		2	
97	A	2			2
98	M	1		1	
99	A	3			3
100	M	1	1		
<b>Total</b>		<b>163</b>	<b>13</b>	<b>95</b>	<b>53</b>

**<sup>7</sup>Error Categories:****A** = Allowed**M** = Medically unnecessary**C** = Claim not paid by intermediary

October 28, 2005

Mr. Gordon L. Sato  
Regional Inspector General for Audit Services  
Department of Health & Human Services  
Office of Inspector General, Office of Audit Services  
1100 Commerce St., Room 632  
Dallas, Texas 75242

Re: Report No. A-06-03-00078  
Written Comments on Behalf of Gulf Health Care Center

Dear Mr. Sato:

We are writing on behalf of Gulf Health Care Center ("Gulf"), in response to the draft audit report received from the Department of Health and Human Services, Office of Inspector General ("OIG") on June 30, 2005.<sup>1</sup> This letter represents Gulf's written response to the preliminary findings reflected in the draft report. Gulf appreciates the effort of OIG in conducting this audit and welcomes the opportunity to provide comments that will be incorporated into the final report. Because Gulf disagrees strongly with the conclusions reached as to nearly all of the audited claims and has concerns regarding the procedures, processes and analyses applied by Tricenturion Safeguard Contractors ("Tricenturion") in connection with the audit, Gulf urges OIG to reconsider the conclusions reached in its draft report, for the reasons set forth more fully herein.

### **BACKGROUND**

In conducting the audit, OIG selected a sample of 100 Medicare rehabilitation claims made between July 2, 2002 and May 31, 2003. The 100 audited claims purportedly contained 163 Resource Utilization Groups ("RUGs"), totaling \$523,370.00. Representatives of OIG visited Gulf's Texas City, Texas, facility in order to photocopy medical records they selected as relevant to these claims, which we have been informed were then delivered to, and reviewed by, clinical auditors from Tricenturion (a third-party contractor) on OIG's behalf. These reviewing auditors have never visited Gulf and, instead, have relied solely upon the records provided by OIG.

As reflected in the draft report and the auditors' worksheets provided to Gulf by OIG, OIG ultimately concluded that nearly all (95 out of 100) of the claims included medically unnecessary or inadequately documented services. OIG's draft report contends that 90 of the claims included RUGs that should be either denied or downcoded on the grounds that the services provided to patients were medically unnecessary, and that the remaining five claims should be denied or downcoded because documentation supporting the services provided was purportedly missing or insufficient. After allegedly applying the RAT-STATS program to calculate an extrapolated overpayment, OIG projects a purported overpayment to Gulf of

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<sup>1</sup> OIG has extended the timeframe for Gulf to submit this response.

\$1,345,060, which represents approximately 64% of Gulf's total Medicare claims for that one-year period.

During the period encompassed by the audit, Gulf was a nursing and skilled nursing facility that participated in both the Medicare and Medicaid programs. During that period, Gulf was owned by HealthMark Partners, LLC.

The rehabilitative services provided at the Gulf facility during this period were provided "under arrangement" by an unrelated third-party contractor, Kindred Rehab Services, Inc. d/b/a *Peoplefirst* Rehabilitation. ("Peoplefirst"). Kindred Rehab Services, Inc. is a wholly-owned subsidiary of Kindred Healthcare, Inc. ("Kindred"). Kindred and its wholly-owned subsidiaries—including *Peoplefirst*—operate under both a Corporate Integrity Agreement ("CIA") with OIG and strict compliance programs that were created to reinforce a company-wide commitment to comply with applicable federal and state laws, regulations, and guidelines, as well as company policies. *Peoplefirst* has been a provider of rehabilitative services to long-term care facilities, hospitals, school systems and outpatient centers nationwide for more than fifteen years.

Upon receiving notice of the OIG's draft report, Gulf requested that *Peoplefirst* conduct a comprehensive review of the reviewing auditors' worksheets provided by OIG, the relevant medical records, and various relevant rules, regulations and other reference materials. Through this independent analysis, *Peoplefirst* reached a conclusion in stark contrast to that of OIG. Specifically, *Peoplefirst* informs Gulf that 85 of the 95 claims clearly were valid and were improperly rejected in the draft audit report. Based on *Peoplefirst*'s analysis and an independent analysis by a nursing expert, an additional six claims were improperly rejected and should have been approved, albeit perhaps at a lower RUG level than that billed. Thus, at most, Gulf agrees with OIG's recommended determinations as to only four claims.<sup>2</sup> Moreover, under these circumstances, Gulf believes that it is improper to extrapolate any results to a larger universe of claims and reserves the right to challenge any decision to make such an extrapolation, as well as the validity of the sampling itself.

#### SUMMARY OF GULF'S RESPONSES

After careful review and critical analysis, we believe there are only four claims out of the 100 reviewed that may have been appropriately denied.<sup>3</sup> As to an additional six claims, *Peoplefirst*'s analysis concludes that the RUG level billed may have been too high. However, even as to these claims, OIG failed to apply a proper downgrade. As to the remaining 85 claims, Gulf believes that the claims were improperly denied or downcoded and were billed appropriately. The attached chart (Exhibit "A") provides a brief summary of each claim individually, indicating whether Gulf's analysis refutes or may support OIG's findings.<sup>4</sup> Additionally, Gulf is sending to OIG under separate cover an individual letter regarding each of

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<sup>2</sup> Even as to these four claims, while Gulf does not at this time dispute a downcode or denial based on its review to date, Gulf reserves the right to dispute OIG's conclusions at a later date.

<sup>3</sup> See fn. 1.

<sup>4</sup> See fn. 1.

the claims for which Gulf's analysis refutes OIG's recommendations and findings, as well as any supporting documentation OIG has contended was "missing" from the facility's medical record for that patient and which appeared to influence OIG's analysis.

There are several reasons why Gulf believes OIG's conclusions are in error:

- In at least 27 cases, OIG appears to have recommended the denial of a claim (or refused to recommend a downcode) on the basis of missing or inadequate documentation. In actuality, in many of these cases, the documents were easily found in the facility's medical record for the patient and appear simply to have been overlooked by OIG. In other cases, the reviewing auditors improperly recommended denial of the claim on the basis of technical document deficiencies, without considering the medical records in their entirety, as required.
- In at least 40 cases, the reviewing auditors mention dementia, Alzheimer's disease or other cognitive impairments as a basis for denying therapy to the patient and appear to believe that patients with these cognitive deficits cannot participate in, and benefit from, rehabilitation services. This unfounded presumption is contrary to stated Centers for Medicare & Medicaid Services ("CMS") policy and, in many cases, disregards the fact that the patient not only participated in therapy, but showed actual improvement.
- Gulf believes that many of the reviewing auditors' conclusions regarding the medical necessity of the rehabilitation services at issue are unfounded. For example, in several cases, the reviewing auditor rejected the medical necessity of skilled nursing facility ("SNF") care, concluding that home health care was appropriate, without properly considering the patient's condition or his/her home environment, as required by CMS policy. Additionally, the reviewing auditors frequently relied heavily upon inappropriate considerations, like the fact that the patient was a prior long-term care resident or was of "advanced age." In many cases, the reviewing auditors also took into account later events beyond the relevant review period, such as a patient's eventual medical decline or ultimate death.
- The reviewing auditors also overlook the fact that it is the physician who determines whether therapy is appropriate, not the facility. It would be improper for the facility to disregard the instructions of the patient's attending physician.
- OIG has recommended total denial of approximately 61 claims without recommending any RUG downgrade. Gulf believes that nearly all of these claims are appropriate at the RUG level billed. Even if OIG disagrees, however, Gulf believes that OIG has overlooked and improperly refused to recommend clearly available RUG downcodes.
- It appears from the draft report and supporting auditor worksheets that the reviewing auditors did not properly apply Medicare Program Integrity Manual guidelines. For example, the reviewing auditors' determinations reflect apparent confusion regarding the Medicare SNF Prospective Payment System ("SNF PPS"). It also appears that the auditors did not properly account for presumptive coverage.

This letter contains illustrative examples of cases demonstrating the concerns outlined above. Additionally, as noted above, we are sending under separate cover (to protect patient



privacy) a detailed response letter addressing each of the claims at issue, including these examples.

Two specific examples are particularly illustrative of the reasons why Gulf requests that OIG reevaluate its draft audit report. The first is the case of *Patient A, Sample Nos. 71 and 86*, which served as one of only two examples in the narrative of OIG's report (see p. 4) and whose two claims OIG recommends denying. *Patient A* is an 83 year-old man who was living at home independently with his wife until he was hospitalized in late 2002 due to increasing falls and an unsteady gait. He was found to have a subdural hematoma, intraventricular hemorrhage, and bifrontal contusions. He was admitted to the Gulf facility on January 28, 2003, and the two claims at issue cover the one-month period from his admission until February 28, 2003.

In recommending denial of *Patient A's* claims, the reviewing auditor relies heavily upon the patient's history of Alzheimer's disease, commenting in the audit worksheet that "[i]t is clear that he suffers from a chronically debilitating condition (Alzheimer's) that cannot be expected to improve . . . his deficits were not the result of a traumatic brain injury, but progressive dementia." After making a unilateral diagnosis of the cause of the patient's deficits, the auditor concludes that it is "unrealistic" to expect the patient to retain instructions or improve, or to return safely to his home without constant supervision.

These comments are both unfair and unfounded. In truth, *Patient A's* condition improved greatly through therapy, as reflected in a March 13, 2003 physician's note, which comments that he "has done really well since admission." With therapy at Gulf, he demonstrated improvement in every category and ultimately was discharged home in March 2003. Without therapy, this patient would have remained at the Mod/Max level of care and almost certainly would have spent the remainder of his life in a nursing facility. *Patient A's* case is discussed in greater detail in the individual analysis submitted under separate cover.

An even more startling example is the case of *Patient B, Sample No. 41*. In that case, the reviewing auditor concedes in the worksheet we received from OIG that the occupational therapy ("OT") and physical therapy ("PT") services provided were appropriate, but determines that speech therapy ("ST") was not appropriate, due to the patient's "memory deficits." As a result, the reviewing auditor recommends a downcode from RUA11 to RMA11. In fact, *no ST services were provided or claimed during the period in question*. Thus, the auditor's conclusion represents clear error and should be corrected.

## DISCUSSION OF GULF'S CONCERNS REGARDING OIG'S PRELIMINARY FINDINGS

The following summarizes the areas of concern that form the basis for Gulf's request that OIG reconsider the recommendations made in the draft audit report.

### **1. Much of the documentation the draft report identifies as missing or incomplete was, in fact, readily available for review.**

In at least 27 cases, OIG has improperly denied or downgraded a claim at least in part based on the apparent grounds that the facility's medical record for the patient lacked sufficient documentation to support the claim. In most of these cases, the documentation the auditors identify as missing was, in fact, easily found in the patient's records. To the extent OIG is unable to locate the "missing" documentation, Gulf will be forwarding documentation it has located that was apparently not considered in OIG's analysis under separate cover with its detailed discussion of each individual claim. Gulf also would be happy to provide any additional documentation OIG identifies as relevant to its analysis of the claims at issue.

The following cases are just a few examples of the auditors' improper denials or downgrades due to purportedly "missing" documentation:

- *Patient C, Sample No. 89:* In recommending that this claim be denied, the reviewing auditor cites "insufficient documentation," commenting that OT and PT evaluations and notes, nursing notes, a SNF order and other relevant documents are not present. This is incorrect, however. The patient's medical record contains extensive documentation supporting the medical necessity of this patient's therapy, including hospital progress notes, physician's orders, PT and OT evaluations and notes, physician's progress notes, nursing notes, MDSs, and other relevant documents.
- *Patient D, Sample No. 23:* In recommending denial of this claim, the reviewing auditor suggests that a downgrade to SE111 would have been permitted, but for the lack of a "valid order for SNF." In reality, the patient's medical record includes a certification and re-certification signed and dated by the physician, a signed and dated physician's order ordering re-admission to Gulf, as well as signed and dated physician's notes taken during the patient's SNF stay.
- *Patient E, Sample No. 33:* The reviewing auditor recommends that this claim be downgraded to the RMB level based, in part, on allegedly missing OT documentation. In fact, the relevant OT documentation was easily located in the medical record for this patient, as were the purportedly missing re-certification, 14-day MDS and hospital discharge summary.
- *Patient F, Sample No. 91:* The reviewing auditor recommends that this claim be downgraded to a AAA11 RUG "due to missing MDS for the 5-day assessment." The 5-day MDS is present in the patient's medical record, however.

Moreover, many claims were improperly denied on the basis of purported technical deficiencies in documentation without considering the medical records in their entirety. For

example, the reviewing auditors in some cases propose denying payment for skilled services if the physician's signatures on the orders for services do not also have a date. In other cases, the reviewing auditors make an adverse recommendation on a claim based on missing SNF orders or certifications, without considering whether other documents in the patient's medical record as a whole satisfied certification requirements.

Section 220 of the SNF Coverage Manual makes clear that there are no specific procedural or form requirements for certifications and re-certifications, "as long as the approach permits a verification that the certification and recertification requirement is met." See SNF Coverage Manual regarding Physician Certification and Recertification (attached as Exhibit "B"). In fact, the provider "may adopt any method that permits verification," and the certification/recertification "may be entered on forms, notes, or records that the appropriate individual signs." 42 C.F.R. § 424.11(b) (attached as Exhibit "C"). Further, if the required information "is contained in other provider records, such as physicians' progress notes, it need not be repeated." *Id.* at 424.11(c). This approach also comports with the Mutual of Omaha Local Coverage Determination ("LCD") for Medicare Skilled Nursing Facility Coverage for Rehabilitative Services Resource Utilization Group (RUG III) Category (L20618) (attached as Exhibit "D"). This document clearly states that no specific procedure or form is required.

This view is also consistent with other policy documents issued by CMS. In Transmittal 74 (Change Request 3150), issued April 23, 2004, CMS emphasized that "fiscal intermediaries should consider documentation in the beneficiaries' medical record to determine if the required elements for certification are present. A discrete form is not necessary." (attached as Exhibit "E"). Transmittal 74 emphasizes that recent rulings by administrative law judges and the Medicare Appeals Council have reinforced the obligation that fiscal intermediaries consider medical records in their entirety to determine if the required elements for a certification are present. See, e.g., In the case of Spring City Healthcare Center, Decision of Medicare Appeals Council dated April 27, 2004 (finding that the plans of care in the patients' medical record satisfied the content requirements for certification of SNF services) (attached as Exhibit "F").

It was therefore improper for the reviewing auditors to retrospectively deny or downgrade claims based upon isolated technical deficiencies in individual documents, like undated forms or purportedly invalid certifications, without considering the medical record in its entirety. For example:

- In the case of *Patient G, Sample No. 40*, the reviewing auditor conceded that this patient "requires physical, occupational, and speech therapy to assist patient to become as independent as possible." The reviewing auditor recommends a downgrade, however, because of an allegedly missing 5-day Minimum Data Set ("MDS"), missing OT documentation and a certification/re-certification that was not dated by the treating physician. Not only were the 5-day MDS and OT documentation (including an OT evaluation and daily notes) present in the files, but the records, when considered in their entirety, clearly demonstrate that the treating physician was involved in, and authorized, the patient's need on a daily basis for rehabilitation services. The lack of date by the physician's signature on the certification/re-certification, by itself, is not a valid basis for denial of the claim. Additionally, Gulf has obtained a delayed physician's

certification for this claim, which will be forwarded separately, as permitted by CMS. See below.

- OIG recommends denial in the case of *Patient H, Sample No. 64*. The reviewing auditor comments that a downgrade would have been permitted “but there is no valid physician’s order for skilled care” purportedly because “the physician intended this patient to receive nursing home care.” This is not the case, however. Not only did the physician sign the transfer form sending this patient to Gulf, but the patient’s medical record contains clarification orders for all three therapies, physician co-signed progress notes, other physician notes and nurse’s notes reflecting physician orders. This makes clear the physician’s intent and expectation of patient improvement with skilled therapy services and knowing participation in the patient’s care.
- *Patient I, Sample No. 5*: The reviewing auditor denied this claim, and refused to apply a downcode that the reviewing auditor conceded would be appropriate, on the basis of allegedly missing documents. Although the auditor contends that there were no progress notes, orders or a certification to indicate the physician’s intent to discharge the patient to SNF, this is not the case. The physician’s intent that his patient receive therapy in the SNF is clear from the physician’s progress notes referencing PT, OT, and ST, various physician’s orders, nursing notes indicating physician involvement in therapy, and a History and Physical (“H&P”) signed by the physician.

Finally, to the extent that a purportedly defective certification or re-certification affects OIG’s decision regarding a particular claim, Gulf is permitted to obtain a delayed physician certification. See SNF Coverage Manual §220.5 (Exhibit B). In the cases of *Patient G (Sample 40)*, described above, as well as *Patient J (Sample 65)*, Gulf has done so, and these delayed certifications are being forwarded under separate cover.

**2. OIG’s findings reflect inappropriate preconceptions regarding patients suffering from dementia, Alzheimer’s disease or other cognitive impairments.**

The auditors appeared to lack an understanding or appreciation of the fact that patients with dementia or other cognitive impairments can participate in, and benefit from, rehabilitation services. In at least 40 cases (about 42% of the rejected claims), the reviewing auditors’ worksheets mention dementia, Alzheimer’s disease, or other cognitive impairments as a basis for denying therapy to the patient. The reviewing auditors frequently appear to have applied a presumption that cognitively impaired patients could not participate effectively in therapy, often disregarding the fact that the patient’s medical record reflects not only participation, but improvement.

This approach toward patients with cognitive impairments is clearly contrary to CMS policy. In fact, CMS has issued a technical clarification to Medicare contractors forbidding those contractors from using ICD-9 codes for dementia as a basis for determining whether a Medicare covered benefit was reasonable and necessary. See CMS Program Memorandum AB-01-135 “Medical Review for Patients with Dementia” (issued September 25, 2001) (attached as Exhibit “G”). In a statement of April 1, 2002, discussing this clarification, the Administrator of CMS

emphasized that the clarification “reinforces our commitment to making sure that all beneficiaries receive the care to which they are entitled under Medicare.”

The Administrator’s statement further explained the reason for the clarification, which was to prevent exactly what has happened here—the denial of services based on cognitive impairment:

Advances in medical science are helping physicians diagnose Alzheimer’s Disease at its earliest stages. Depending on a beneficiary’s medical condition, the Centers for Medicare & Medicaid Services believes that certain specific therapies can be helpful in slowing a beneficiary’s decline due to this terrible illness.

In response to advocate concerns that Medicare contractors were increasingly denying services to Medicare beneficiaries based solely because they had been diagnosed with Alzheimer’s Disease, CMS issued the memorandum to clarify existing reimbursement policies. The September 2001 instructions direct Medicare contractors not to install system edits that would automatically deny Medicare covered services based solely on claims for dementia.

These actions clarify that Medicare would provide payment for specific speech, occupational and rehabilitation therapies . . . Alzheimer’s advocates came to us with what seemed to be a significant problem for Alzheimer’s patients.

**Intuitively, this longstanding approach appeared to discriminate against Alzheimer’s patients, and we were happy to fix it.**

See “Statement of Tom Scully, Administrator Centers for Medicare & Medicaid Services, On Therapy Coverage of Alzheimer’s Disease Patients” (April 1, 2002) (emphasis added) (attached as Exhibit “H”).

Here, it is apparent that if a patient had a diagnosis of dementia, the reviewing auditor concluded that rehabilitation services should be denied, either in full or in part. It is clear that the reviewing auditors’ focus was on the dementia diagnosis, not the patient’s need for skilled rehabilitative services to treat documented functional deficits. The following excerpts are only a few examples of the reviewing auditors’ inappropriate treatment of claims involving cognitively impaired patients:

- As previously discussed, OIG features the case of *Patient A, Sample Nos. 71 and 86*, in the text of its report and, in recommending a denial of this patient’s claims, relies heavily upon the patient’s history of Alzheimer’s disease. The reviewing auditor commented that it is “unrealistic” to expect the patient to retain instructions or improve, or to return safely to his home without constant supervision. Not only did *Patient A*’s condition improve greatly through therapy, but he ultimately was discharged home in March 2003.
- OIG recommends that the claim of *Patient K, Sample No. 61*, be downcoded to a lower RUG level due to the patient’s cognitive status. This patient is a 79 year-old man who was hospitalized following a cerebrovascular accident (“CVA”) and previously lived independently at home with his wife. The claim at issue represents the first two weeks of

his treatment and, at the time of his admission to Gulf, the prognosis for his improvement was good based on his past progress, motivation to improve, and significantly high level of function prior to his stroke. At the level billed, the patient was receiving less than one hour of therapy per discipline per day. Moreover, notwithstanding some unanticipated agitation and anxiety that affected his participation in therapy, the patient did make progress in all aspects of therapy.

- OIG also recommends a downcode in the case of *Patient E, Sample No. 33* (previously discussed above). The patient is an 81 year-old woman who was hospitalized after a CVA but who had previously lived alone. The reviewing auditor based this recommendation on missing OT documentation (which, as explained above at p. 5, was readily found in the medical record) and the patient's purported inability to participate in therapy due to her "cognitive deficits." Given this patient's prior functional status, it was reasonable to assume that she could progress toward independence with appropriate therapeutic intervention. The medical record demonstrates that the patient actively participated in therapy and made progress at a level to be expected of a stroke victim. The concerns noted by the therapists that were related to the patient's high distractibility and impulsive behaviors are consistent with impairments of a patient who has suffered a stroke. The level of care and number of minutes provided were consistent with the needs of a patient with a new onset CVA without significant medical complications.
- OIG recommends a complete denial in the case of *Patient L, Sample No. 51*. *Patient L* is a relatively young patient (70 years old) with a history of Alzheimer's disease and who suffered a traumatic subdural hematoma due to a reported fall. The reviewing auditor relied heavily upon the patient's cognitive condition in recommending a denial of the claim, commenting that "[h]er impaired cognitive status is insidious and precludes her from attaining any long-term benefit from skilled therapy." This statement appears to be based upon presumption, not fact. In actuality, this patient made significant progress towards PT, OT and ST short-term goals within a reasonable period of time, as reflected in the progress notes written by all disciplines. Based on the patient's traumatic head injury, high prior level of function and the physician's expectation of improvement, it was entirely appropriate for her to receive skilled services.

It thus appears that the reviewing auditors improperly used a patient's cognitive status as a key factor in determining eligibility for therapy in many cases. In fact, the reviewing auditor in the case of *Patient M, Sample No. 87*, expressly states as much, commenting in the worksheet that "[b]ecause this patient was living at home independently and did not have cognitive deficits, medical review will ALLOW services as billed." (emphasis added)

These troubling examples continue to reflect a predisposition toward denying rehabilitative therapy for patients with mental deficiencies. The reviewing auditors recommended denials or downcodes for claims even when the therapy notes evidence that the patient was an active participant in therapy and made functional gains through therapeutic intervention. It appears that the reviewing auditors' focus was on the diagnosis of dementia, not the patient's need for skilled rehabilitation services to treat documented functional deficits. In light of the discriminatory effects of such an approach, and because CMS policy on this issue is clearly contrary to these results, Gulf urges OIG to reconsider its preliminary decisions regarding patients suffering from cognitive deficits.

**3. Many of the auditors' conclusions regarding medical necessity are unfounded for other reasons.**

In addition to the reviewing auditors' improper treatment of patients with cognitive deficits, Gulf also generally questions many of OIG's findings regarding lack of medical necessity for other reasons. In many cases, the reviewing auditor's findings that patients' needs were purely custodial, or could have been addressed via home health or outpatient care, is unfounded. Additionally, in many cases the reviewing auditor appeared predisposed against a finding of medical necessity when the patient was of "advanced age" or previously lived in a long-term care facility. Further, the reviewing auditors frequently took into account events outside the period under review—inappropriately using "hindsight" to evaluate the appropriateness of a rehabilitation assessment.

*Inappropriate Findings With Respect to Home Health Care*

In many cases, the reviewing auditors asserted that the services provided could have been provided by home health care services and, therefore, placement in the SNF was inappropriate. A significant percentage of these claims involved patients who previously had lived independently in the community. Frequently, those patients participated in a short-term acute rehabilitation stay prior to placement in the SNF. In those situations, the patients may have been functioning at a higher level than the typical long-term care patient but, nonetheless, were not functioning at a level that was safe for an independent living environment. In addition, as a practical matter, typically the resources necessary to return to the home environment, such as available family assistance to navigate around the home—a practical necessity in order for home health care services to be a viable option—were not available to meet the patients' needs.

The SNF Coverage Manual § 214.6 provides that "[t]he availability at home of capable and willing family or the feasibility of obtaining other assistance for the patient should be considered." (attached hereto as Exhibit "I"). Thus, even though the needed daily skilled services might be available on an outpatient or home health care basis, as a practical matter, the care may be available only in the SNF if home care would be ineffective because of insufficient assistance at home to ensure the patient's safety.

The reviewing auditors rarely appeared to consider a patient's home environment and safety issues that might have arisen if the patient were sent home. Further, in many cases, the rehabilitation services required were of a complexity and intensity that was not appropriate for a home environment. For example:

- In the case of *Patient N, Sample No. 80*, OIG recommends a complete denial of a one-week claim for an 80 year-old patient who was hospitalized after suffering a fall and who was diagnosed with severe degenerative joint disease of the left hip. The reviewing auditor comments that the patient "does not demonstrate significant functional deficits requiring therapy within a SNF." Although this patient may have been at a functional level higher than most when she entered the SNF, she still had not reached her prior level of function necessary to return home. As reflected in the hospital transfer form, this patient was deemed unable to return home safely. She continued to be at risk for falls,

and she also needed care for a stage II wound. Moreover, her treating physician ordered OT and PT therapy “BID,” which a patient cannot receive from home health. The patient ultimately accomplished her goal to return home in a very short period of time with the assistance of the skilled therapists at Gulf.

- OIG also recommends a complete denial of a one-week claim for *Patient O, Sample No. 24*, an 81 year-old patient hospitalized for a total right hip arthroplasty earlier in the month of her SNF admission. Notwithstanding this significant hip surgery, the reviewing auditor concludes that this patient could have been discharged home to receive therapy via home health services or admitted to a custodial care facility for outpatient therapy. Though the patient spent two weeks in acute rehab prior to her SNF admission, it is clear that she required continued skilled therapy in order to increase her functional independence to enable her to return home safely. When discharged from acute rehab, she had not yet had therapy addressing stairs (she lived in a home with 21 steps), car transfers, homemaking and home care activities. The treating physician also agreed that the patient required PT and OT services 5 days per week, which constitutes a skilled level of care and supports SNF placement. The patient progressed in therapy and ultimately returned home in a relatively short period of time.
- In the case of *Patient P, Sample No. 27*, the reviewing auditor again overlooked the fact that the level of intensity of therapy that the patient required could not be provided in the home health setting. This patient, a 79 year-old woman, sustained a cervical spine fracture with anterior longitudinal ligament subluxation following a syncopal episode and fall at home. She underwent a corpectomy with spinal fusion prior to her SNF admission. She required PT and OT services a minimum of 5 days per week in order to return to her prior level of independence at home, which could not have been provided via home health.

The reviewing auditors’ misplaced reliance upon home health care is perhaps most glaring in the case of *Patient Q, Sample 50*, an 84 year-old woman who the reviewing auditor suggests “could receive outpatient therapy if necessary and be transported for wound care in the nursing home setting.” It is difficult to imagine why the reviewing auditor believed this scenario to be feasible, much less in the best interest of the patient.

#### *Improper Considerations Regarding Patients of “Advanced Age” and Facility Residents*

The reviewing auditors also appear to have a preconceived opinion that if the patient was a resident of the facility prior to hospitalization, there was a decreased, or absence of, need for therapy services upon the patient’s readmission to the SNF. The auditor worksheets provided by OIG also reflect a bias against patients of “advancing age,” because the reviewing auditors often appeared to use the patient’s age as a yardstick in evaluating whether that patient’s care was appropriate. For example:

- OIG recommends a complete denial in the case of *Patient R, Sample No. 69*, in part because the patient purportedly was unable to participate in therapy at the billed level “due to advanced age and encouragement to participate.” The reviewing auditor concludes that the patient’s therapeutic needs, resulting from hip surgery, should have



been addressed by home health care. However, the patient's care could not have been handled safely through home health services, given the significant changes in her health status, frequent monitoring of labs, pain management and need for PRN oxygen. In fact, an assisted living facility ("ALF") evaluated the patient during this period and found her not to have sufficient independence for an ALF placement. It is also unclear why the reviewing auditor believed the patient's age or motivation to be problematic, particularly in light of the fact that, *ultimately, the patient was discharged to an ALF with improved safety and a decreased risk of falling.*

- In the case of *Patient S, Sample Nos. 18, 34 and 73*, OIG recommends that the patient's claims be downgraded. Though the reviewing auditor concedes that the patient "required the skills of physical and occupational therapy to improve his ability to care for himself and return home," the reviewing auditor concludes that this 83 year-old patient could not participate at the intensity level billed primarily due to his "advanced age" and "lack of motivation." More relevant than the patient's age and motivation, however, are his levels of participation and improvement. Medical records demonstrate that this patient never completely refused treatment and was motivated to recover by making statements like "I want to get stronger" and "I want to walk more." Social service and physician progress notes reflect the view that this patient "is making progress" and should "continue therapy daily." Thus, the intensity of services provided was medically appropriate given the reasonable belief that the patient would return home and the patient's motivation to do so.

#### *Improper Consideration of Future Events*

Additionally, the reviewing auditors frequently took into consideration future events that were not known by the therapist at the time of the therapy assessment. These future events (such as a patient's later death or rehospitalization) were not known, and could not have been known, to the therapist at the time of assessment, and Gulf's claims should not be judged with 20/20 hindsight. For example:

- In the case of *Patient T, Sample No. 68*, OIG recommends denial of the claim, suggesting that this 94 year-old patient with a spinal fracture should not have received therapy at Gulf. Instead, the reviewing auditor concludes that only wound care and hospice care were appropriate, apparently based upon the fact that the patient died in the month following the treatment period at issue. Given that the patient previously lived at home independently, had a good prognosis to return to his prior level of function during the period at issue, and made progress with therapy, it is inappropriate for OIG to consider the patient's later unexpected decline and death.
- OIG recommends a downcode to a skilled nursing level in the case of *Patient U, Sample No. 57*. The reviewing auditor contends that this 77 year-old patient, hospitalized for pneumonia, did not warrant skilled therapy, noting the patient's "declining medical condition, advanced age, and cognitive deficits." The reviewing auditor notes that the patient (after the relevant time period) was admitted to hospice and ultimately died. This recommendation fails to take into account that the patient had made improvement with prior rehabilitation. Thus, it was reasonable for the therapists to expect continued

progress at the time of evaluation. The therapists had no way of knowing that the patient was going to experience a significant decline in health status in the future.

*Failure to Consider Patient Quality of Life and Prevention of Deterioration*

The reviewing auditors also frequently commented that a patient's therapy was not warranted because the patient could not be expected to improve, thus clearly failing to recognize that skilled therapy is appropriate not only in cases where the patient is assured of making progress, but also to prevent deterioration and ensure quality of life. The nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987 mandate that nursing facilities provide programs that encourage residents to function at their highest possible level. See 42 U.S.C. § 1395i-3(b)(2) (attached hereto as Exhibit "J"). CMS rules implementing these provisions require that:

[E]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

42 C.F.R. § 483.25. (attached hereto as Exhibit "K"). Patients also have a right "to be free from contractures, restraints, incontinence, pressure sores, weight loss and functional decline in mobility and activities of daily living." Id.

If a patient demonstrates a decline in function due to a hospitalization, a reasonable expectation exists that the patient can recover those functional skills if the appropriate skilled services are provided. As an example, although a patient's medical diagnosis may be self-limiting, therapy may still be warranted to address the effects of immobility (which may include decreased endurance, muscle disuse atrophy, and an increased risk of skin breakdown, dehydration and falls). In fact, the SNF Coverage Manual makes clear that "[w]hile a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled." SNF Coverage Manual § 214.1 (Exhibit I).

Thus, to the extent that the reviewing auditors' recommendations are based solely upon a conclusion that a patient cannot be expected to fully recover, this is directly contrary to CMS policy:

Even where a patient's full or partial recovery is not possible, a skilled service still could be needed to prevent deterioration or to maintain current capabilities. A cancer patient, for instance, whose prognosis is terminal may require skilled services at various stages of his illness in connection with periodic 'tapping' to relieve fluid accumulation and nursing assessment and intervention to alleviate pain or prevent deterioration. The fact that there is no potential for such a patient's recovery does not alter the character of the services and skills required for their performance.

SNF Coverage Manual § 214.1 (Exhibit I). Moreover, it is wholly inappropriate for the reviewing auditors to make generalizations regarding a patient's lack of potential for recovery without examining the patient's total condition and need for care:

"Rules of thumb" in the [Medical Review] process are prohibited. Intermediaries must not make denial decisions solely on the reviewer's general inferences about beneficiaries with similar diagnoses or on general data related to utilization. Any "rules of thumb" that would declare a claim not covered solely on the basis of elements, such as lack of restoration potential, ability to walk a certain number of feet, or degree of stability is unacceptable without individual review of all pertinent facts to determine if coverage may be justified. Medical denial decisions must be based on a detailed and thorough analysis of the beneficiary's total condition and individual need for care.

CMS Program Integrity Manual, Chapter 6.1, "Medical Review of Skilled Nursing Facility Prospective Payment System (SNFPPS) Bills" (attached hereto as Exhibit "L"). Thus, those recommendations for denial or downgrading of claims that are based solely upon the likelihood of full recovery are improper. The following cases are just a few examples:

- In the case of *Patient V, Sample 58*, the reviewing auditor's primary basis for downgrading to the SE111 level was an opinion that this 91 year-old woman was in a "chronically debilitated condition" that "cannot be expected to improve significantly within a reasonable and generally predictable time period." This patient was previously independent with basic ADLs and lived at her daughter's home. She was diagnosed with exacerbation of COPD, right lower lobe pneumonia and Afib with RVR. Based on the information provided to the facility regarding her prior level of function and recent onset of weakness, it was expected that she would make a predictable recovery within a short period of time and, in fact, during the month of January (this claim was for January 22-31), she did progress in all of her goals. Her decline did not begin until the following month. Thus, not only is the reviewing auditor incorrect in assessing the patient's potential for improvement during the relevant period, at the very least, the auditor should have considered the facility's obligations to prevent this patient's deterioration and maintain her current capabilities.
- Similarly, OIG recommends downgrading the claim for *Patient W, Sample 44*, an 85 year-old woman hospitalized due to acute respiratory failure based upon the belief that she was a "hospice candidate with multi-factorial illnesses and a poor prognosis." Reliance on this prognosis was not appropriate, however. This patient had significant potential for further decline in her physical function, which therapy services were intended to prevent. Therapy also was delivered to improve her overall quality of life by improving her ability to communicate basic information, prevent skin breakdown related to immobility, prevent increased contractures, and prevent isolation related to inability to maintain an upright sitting posture.

Contrary to the apparent views of the reviewing auditors, assessing a patient's need for therapeutic services is never clear cut. As made clear in the SNF Coverage Manual, the patient's

overall medical condition must be taken into account.<sup>5</sup> Moreover, even services that might ordinarily be considered nonskilled could be considered a skilled service where medical complications are involved.<sup>6</sup> In many cases, the reviewing auditors' conclusions regarding medical necessity do not appear to take such considerations into account.

**4. In many cases, the reviewing auditors recommend denial of claims without applying appropriate downcodes or, when recommending downcodes, did not follow proper Medicare Program Integrity guidelines.**

In more than half of the cases, OIG recommends the wholesale denial of the claim, without applying any RUG downgrade. As explained in detail in the individual response letters that will be provided under separate cover, Gulf believes that nearly all of these claims were billed at the appropriate RUG level and, therefore, neither denial nor downcoding is appropriate. At the very least, however, the reviewing auditors should have recognized and applied an appropriate RUG downgrade. Moreover, even as to the ten claims for which the Peoplefirst review concludes, in hindsight, that therapy services may not have been appropriate at the level claimed, OIG did not take into consideration the fact that Gulf is at least be entitled to payment under a lower therapy or nursing RUG in six of these cases. For example:

- *Patient X, Sample 96*, an 81 year-old man suffering from aspiration pneumonia, malnutrition and dehydration, clearly required and received skilled nursing services. His medical records reflect that he received intravenous or intramuscular injections and intravenous feeding; nasopharyngeal and tracheostomy aspiration; application of dressings involving prescription medications and aseptic techniques and treatment of extensive decubitus ulcers or other widespread skin disorder. Thus, at a minimum, a downgrade to the SE2 RUG level was appropriate.
- *Patient Y, Sample 95*, a 91 year-old male patient, clearly qualified for and received skilled nursing services because he had a PEG tube placed, and nurses administered enteral feeding during the relevant period in excess of 26% of his daily caloric intake and greater than 501 cc of fluid per day. At a minimum, a downgrade to a Special Care RUG level should have been recommended.
- *Patient Z, Sample 29*, a 68 year-old man suffering from a new brain stem CVA, received skilled nursing observation and assessment. His medical condition was unstable, and

<sup>5</sup> For example, as described in the SNF Coverage Manual: *A patient with congestive heart failure also has diabetes and previously had both legs amputated above the knees. Consequently, the patient does not have a reasonable potential to achieve ambulation, but still requires daily skilled physical therapy to learn bed mobility and transferring skills, as well as functional activities at the wheelchair level. If the patient has a reasonable potential for achieving those functions in a reasonable period of time in view of the patient's total condition, the physical therapy services are reasonable and necessary. See Exhibit I.*

<sup>6</sup> For example, as described in the SNF Coverage Manual: *The existence of a plaster cast on an extremity generally does not indicate a need for skilled care. However, a patient with a preexisting acute skin problem, preexisting peripheral vascular disease, or a need for special traction of the injured extremity might need skilled nursing or skilled rehabilitation personnel to observe for complications or to adjust traction. Similarly, [w]hirpool baths do not ordinarily require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required where the patient's condition is complicated by circulatory deficiency, areas of desensitization, or open wounds. See Exhibit I.*

antibiotics were being administered. He also had poor intake and swallowing problems while being fed. Additionally, his blood sugar was monitored and sliding scale insulin was administered. The overall management and evaluation of his care plan also constituted skilled services because his physical and mental condition required the involvement of professional personnel in order to meet his needs, promote his recovery and ensure his medical safety. The reviewing auditor therefore, at a minimum, should have recommended coverage at the very least, at a Clinically Complex RUG level.

Moreover, even as to the remaining claims that Gulf believes were billed at an appropriate level, the reviewing auditors, in recommending denials, clearly failed to consider the availability of skilled nursing coverage as an alternative. The following are just a few examples of cases in which the claims clearly were appropriate as billed, but for which, at the very least, Gulf is entitled to a downgrade to an appropriate lower RUG level:

- *Patient AA, Sample 68*, is a 94 year-old man hospitalized with worsening back pain and determined to have a compression fracture of T12. His hospital stay was complicated by a pleural effusion, and he was placed on a ventilator. He was admitted to Gulf with a Stage II ulcer on his right heel and Stage III ulcers on his right and left buttocks, per the Admission Nursing Assessment on April 18, 2003. In recommending a denial of this claim, the auditing reviewer disregarded the fact that this patient qualified for presumptive coverage from the day of his admission through the Assessment Reference date of the 5-day MDS due to the daily wound care he received. Additionally, the daily wound care he received made him eligible, at the very least, for a RUG score at the Special Care level for the entire claim period.
- Similarly, *Patient BB, Sample 67*, also received daily skilled wound care for heel ulcers. The auditing reviewer recommends an absolute denial of this claim, however, without taking these undisputed daily skilled services into account. Though the therapy provided to this patient was entirely proper and the claim was billed properly, Gulf was at least entitled to payment at a Special Care RUG level.

Additionally, in those cases in which the reviewing auditors did recommend a downcode, appropriate Program Integrity Guidelines were not followed. The draft report adjusts many claims to lower RUG categories based on the reviewing auditor's interpretation of what constitutes the basis for a denial. However, in many cases it appears that the reviewing auditor did not follow CMS guidelines for adjusting claims, as set forth in Chapter 6 of the Medicare Program Integrity Manual (Exhibit L). There are claims in which no credit was given for skilled nursing services rendered and where ADL scores were not followed. For example, in one case, the reviewing auditor denied rehabilitation services for the patient and recommended a downcode to the PA1 level. This indicates that the reviewing auditor conceded that the skilled nursing services were delivered daily; however, because the patient had received IV antibiotics in the hospital during the look back period, the claim, if denied, should have been adjusted to SE1, not to PA1.

Similarly, with regard to *Patient CC, Sample 12*, the therapy services provided, according to Peoplefirst's analysis, and in hindsight, may not necessarily have been appropriate at the level

billed. However, rather than downgrade the claim to the PA111 level and partially deny the remainder of the claim, as OIG recommends, a downgrade to the RM level is far more appropriate. Without skilled rehabilitation services, this 81 year-old woman would not have had the opportunity to regain her prior level of function. It was necessary for therapists to be involved in her care to support maximizing functional independence at the highest practicable level, as required by statute and implementing rules at 42 C.F.R. § 483.25.

**5. The auditors did not appear to understand or comply with the SNF prospective payment system or presumptive coverage guidelines.**

It is also apparent that the reviewing auditors did not properly understand or consistently comply with the Medicare prospective payment system or presumptive coverage guidelines. Under the Medicare SNF PPS, Medicare payments are made based on the most recent clinical assessment (*i.e.*, MDS) until the next required assessment is due, or until skilled care is no longer required. See CMS Program Integrity Manual, Chapter 6.1 (Exhibit L). This means that the level of payment for each day of the SNF stay may not match exactly the level of services provided. *Id.* Unfortunately, it appears that the reviewing auditors did not take these considerations into account.

For example, in the case of *Patient S, Samples 18 and 73*, the September per diem rate was determined by the August assessment. During a review of the August claim, the reviewing auditor determined that the rehabilitation services were reasonable and necessary, although at a reduced rehabilitation RUG level. The reviewing auditor of the September claim, however, reduced the claim to a nursing RUG level. As a result, there are conflicting determinations involving the same MDS payment cycle.<sup>7</sup>

Additionally, by failing to properly account for the prospective payment process, the reviewing auditors often appeared to analyze the necessity of therapy services *not* at the time of the patient's assessment (as is required), but at a later time. This approach by the auditors failed to consider that, under SNF PPS, providers are to be compensated based on the immediately prior clinical assessment, even if the skilled care needs of the patient later are reduced to a lower RUG level. There is simply no mechanism by which a provider can adjust to a lower RUG level between assessment periods, and it is not appropriate for the reviewing auditors to make decisions without regard to the patient's needs at the time of the assessment.

Similarly, the reviewing auditors apparently also failed to take into account presumptive coverage principles. Because Medicare beneficiaries who require post-hospital care routinely require intensive skilled care during the period immediately following discharge from the hospital, physicians appropriately order that their patients be placed in a skilled setting to meet those patients' needs. To that end, Medicare guidelines recognize a presumption of coverage for the early days of SNF care:

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<sup>7</sup> This inconsistency also serves as further demonstration of the difficulty in making retrospective determinations based solely on the paper record and the lack of fairness in recommending denials on this basis, except in the clearest of cases.

[W]hen the initial Medicare (that is, five-day) required assessment results in a beneficiary being correctly assigned to one of the upper 26 RUG-III groups, this effectively creates a presumption of coverage for the person from admission up to, and including, the assessment reference date for the assessment, and the coverage that arises from this presumption remains in effect for as long thereafter as it continues to be supported by the actual facts of the beneficiary's condition and care needs.

See 64 Fed. Reg. 41666 (July 30, 1999) (attached hereto as Exhibit "M"). This presumption is supported by the Medicare SNF benefit, which is a post-hospital benefit (as distinguished from a long-term care benefit). In several cases, the reviewing auditor improperly denied claims without taking into account presumptive coverage, which would provide Medicare payment for the early days of many patients' first admissions to the SNF. Although Gulf contends that these claims were appropriate at the RUG level billed, at the very least, the reviewing auditors should have considered the availability of presumptive coverage at some lower RUG level. *Sample Nos. 11, 37, 41, 47, 80, and 92* are just a few examples of cases in which presumptive coverage was overlooked.

#### **CONTROLS AND COMPLIANCE PROCEDURES AND THE PRACTICAL REALITIES OF CAREGIVING**

In addition to the concerns outlined above, OIG's rejection of 95 percent of Gulf's sampled claims is questionable in light of the compliance controls and procedures in place during the relevant period. The rehabilitative services at issue here were provided by a third party, *Peoplefirst*, a division of a respected national healthcare services company. *Peoplefirst* has stated to Gulf that its services were performed in strict accordance with Kindred's CIA, as well as its internal compliance policies and procedures.

*Peoplefirst* has explained to Gulf that, as part of Kindred's compliance program, employees of *Peoplefirst* who provide direct patient care receive a minimum of five (5) hours of compliance training each year. Employees receive three(3) hours of "Specific Compliance" training relating to quality of care or responsible billing practices, as well as two (2) hours of "As Needed" training addressing topics determined by Kindred's Quality Committees at the district, regional and corporate levels.

Gulf has also been informed that, because *Peoplefirst*'s therapists provide medically necessary rehabilitation services to medically complex patients recovering from strokes, hip and knee replacements, cardiovascular conditions, respiratory conditions and wounds, *Peoplefirst* also provides oversight and education to its employees on numerous therapy-related topics. These include compliance with applicable federal regulatory coverage guidelines and state practice acts. *Peoplefirst* provides its therapists with formal training regarding dementia and Alzheimer's disease, falls prevention, pain management, continence improvement, edema control, wound management and pulmonary management. *Peoplefirst* has explained that it also routinely reviews and revises its best practices, which have been implemented in an ongoing

effort to improve the quality of its programs and to ensure that its practices comply with applicable federal and state law.<sup>8</sup>

Moreover, the recommendations in the draft report ignore the basic premise of the nursing home reform provisions of the Medicare Act and the practical realities facing front-line care givers on whom residents and facilities rely. As OIG is certainly aware, the Social Security Act requires skilled nursing facilities that provide services to Medicare beneficiaries to “provide services to attain or maintain the *highest practicable physical, mental, and psychosocial well-being of each resident . . .*” 42 U.S.C. § 1395i-3(b)(2) (emphasis added). The Act further requires that “to the extent needed to fulfill all plans of care . . . each skilled nursing facility must provide, directly or under arrangements . . . with others for the provision of (i) nursing and *specialized rehabilitation services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident . . .*” *Id.* (emphasis added).

The regulations that implement the requirements of participation further require that “each resident . . . receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.” 42 C.F.R. § 483.25. Among other things, the rules require that the facility ensure that “(1) a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident’s clinical condition demonstrates that a reduction in range of motion is *unavoidable*; and (2) a resident with limited range of motion *receives appropriate treatment and services to increase the range of motion and/or prevent further decrease in range of motion.*” *Id.* at § 483.25 (e). The requirements of participation further demand that “[i]f specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy . . . are required in the resident’s comprehensive plan of care, the facility must – (1) Provide the required services; or (2) Obtain the required services . . . from a provider of specialized rehabilitative services . . . (b) . . . Specialized rehabilitation services must be provided under the written order of a physician by qualified personnel. *Id.* at § 483.45.

Congress and CMS provided for these requirements as part of the nursing home reform legislation in 1987. That legislation was focused on improving the quality of care in nursing homes. Moreover, the requirements place the responsibility for making these decisions on the judgment of an interdisciplinary team of professionals. Treatment decisions are made by these professionals in real time, often in conjunction with the resident and family members, and with an actual resident facing them.

Congress felt so strongly about compliance with these requirements that it subjected facilities to substantial consequences should they fail to comply with any requirement. These consequences include penalties such as significant fines, denial of payment for new admissions, termination from the Medicare and Medicaid programs, and even immediate closure in an emergency. Moreover, in recent years, facilities have been subjected to significant scrutiny by families and the plaintiffs’ trial bar, and have suffered large verdicts for providing alleged poor care or for allegedly failing to provide services. Under these circumstances, all benefit of the

<sup>8</sup> On January 1, 2005, Healthmark Partners, LLC transferred ownership of Gulf to an unrelated third party. It is our understanding that Peoplefirst no longer provides therapy services to the facility under its new ownership.



doubt must be given to those care givers on the ground who are required to make treatment decisions on a live human being in real time, as opposed to a retrospective look back (such as the OIG's draft report). Unlike the actual care givers, the reviewing auditors performed their analysis with the advantage of 20/20 hindsight, and without the fear of severe sanctions and consequences to the patients for the failure to provide otherwise potentially needed services.

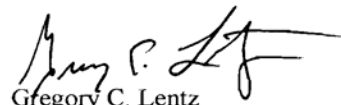
Finally, we would note that the Texas Department of Health surveyed Gulf on three occasions that covered the period of services that were the subject of the audit. Gulf did not have a single deficiency that constituted actual harm ("G level") during that period. Moreover, the surveyors did not cite Gulf for a single deficiency that involved a rehabilitative service. Finally, for the only survey covered during this period by the Federal government's Nursing Home Compare website, Gulf had only 50% of the number of deficiencies of the average Texas skilled nursing facility, and its number of deficiencies was almost equally lower than the average number of deficiencies nationally during the same period. See Inspection Results for Inspection on 7/31/2003 and Complaint Reporting Period of 3/01/2002 through 2/28/2003 (available at [www.medicare.gov/NHCompare](http://www.medicare.gov/NHCompare)). Thus, the Medicare program, and most importantly, the residents of the facility, clearly benefited from the services that Gulf provided.

For these reasons, as well as those described above, Gulf strongly objects to any recommendation that Gulf be denied payment based upon the draft report, except in the clearest case of error. As demonstrated above, these are an extremely small number of cases, if any.

#### CONCLUSION

In summary, Gulf has identified numerous concerns regarding OIG's recommended findings. In light of these significant issues, and for the reasons described above, Gulf respectfully requests that OIG reconsider and re-evaluate the conclusions reached in its June 30, 2005, draft audit report.

Sincerely,



Gregory C. Lentz  
Vice President of Finance &  
Chief Financial Officer  
HealthMark Partners, LLC, on behalf of  
Gulf Healthcare Center